Testimony on Oversight of Group Homes
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Chairwoman Conway, Chairman Hammen, and Members of the Committees,

Thank you for the opportunity to provide testimony regarding the oversight of group homes for foster care youth licensed by the Department of Health and Mental Hygiene (DHMH) and funded by the Department of Human Resources (DHR). We appreciate the interest that you and your colleagues have expressed in reviewing this important issue.

Hundreds of men and women at the Department of Human Resources and Department of Health and Mental Hygiene go to work every day to protect the health and well-being of vulnerable Maryland residents. There is no more important job in state government. We have never hesitated and we never will hesitate to take action when we believe the well-being and safety of the vulnerable adults we serve is being compromised.

We'd like to talk about some of the things we think the state is doing right with group home oversight, as well as some of the things we think we can do better. As with any large and complex system, we know there is always room for improvement.

We have provided detailed attachments on state oversight of group homes and Maryland's Office of Health Care Quality. In our testimony today, we would like to focus on three questions:

1. How do state agencies protect the health and well-being of individuals in group homes?
2. How did state agencies identify and address issues at Lifeline?
3. How can state oversight be improved?

How do state agencies protect the health and well-being of individuals in group homes?

There are many types of group homes for children in Maryland. These include group homes for psychiatric care, therapeutic care, shelter care, programs for children who have

developmental disabilities, and others. In most cases, multiple agencies are involved in assuring the quality of the program and the safety of the children.

In the case of group homes for medically fragile foster care youth, which include Lifeline, DHMH licenses providers under Developmental Disabilities Administration regulations. DHR has contracts with these providers under which medically fragile youth in DHR's custody are placed.

OHCQ and DHR coordinate oversight of these providers. In order to monitor the quality of care being provided, OHCQ conducts annual inspections and investigates complaints and self-reported incidents. In addition, DHR monitors these providers through quarterly visits from its licensing coordinators. Each month, DHR caseworkers also see the youth assigned to them who are placed with these providers.

The agencies have been taking steps to improve the frequency and quality of oversight of regulated facilities. In FY 2014, OHCQ conducted more surveys and investigated more complaints than in FY 2013, and the number is expected to increase again in FY 2015. OHCQ, Developmental Disabilities Administration, and Medicaid are working more closely than ever before to reform quality oversight of facilities serving individuals with disabilities. Weekly meetings allow for coordinated action on facilities and joint planning on major initiatives.

How did state agencies identify and address issues at Lifeline?

As a provider of a group home for medically fragile foster care youth, Lifeline Inc. was licensed by DHMH and funded by DHR. We would like to provide an overview of key points in state oversight and then respond to specific questions.

- **March 2011.** DHMH suspended Lifeline MD/VA's license to provide care for disabled adults. The suspension of this adult license was based on health and safety concerns identified by inspectors at DHMH. At this time, staff at both DHMH and DHR agencies reviewed Lifeline Inc.'s separate license for children and supported continued operation.

- **2011-2013.** During this period, multiple reviews by both DHR and DHMH found acceptable care at Lifeline, Inc. However, there were concerns noted about the financial stability of the organization beginning in April 2012. An audit completed in March 2013 concluded the program was fiscally insolvent. DHR immediately placed Lifeline on the agency Hotlist, restricting any new placements by the local departments. DHR and Lifeline, Inc. entered into a corrective action plan. Lifeline, Inc. completed this plan and was removed from the Hotlist in July 2013.

- **2014.** Regular inspections and investigations of complaints and self-reported incidents revealed health and safety concerns. In May 2014, a DHMH inspector indicated to Lifeline Inc. that DHMH had significant concerns that would likely lead to enforcement action. Shortly thereafter, Lifeline, Inc. indicated that it would close. The agencies began to work on a transition plan. DHR moved all of the children to other locations by early July.

We would like to address five questions raised in media reports about Lifeline.

1. *In 2011, why did the state suspend Lifeline's adult license but not its child license?*

When DHMH suspended Lifeline's adult license in 2001, we considered whether the child license should also be revoked. The children's and adult's sites were in separate geographic locations. At the time, clinical reviews of the care at the facility for youth were acceptable, and the same reviewers at DHMH who supported the decision to suspend Lifeline's adult license did not support an equivalent action for the children's license. DHR staff agreed.

In 2012 and 2013, DHR's oversight and OHCQ's regular inspections and investigations of incidents self-reported by Lifeline, Inc. did not find major problems in clinical care.

2. *Why did DHR re-contract with Lifeline in March 2013 despite evidence of fiscal insolvency?*

Lifeline's contract with DHR was set to expire March 31, 2013. A six-month extension with Lifeline was signed in January 2013 and delivered to the Board in February 2013 in order for it to be placed on the Board's March 6, 2013 agenda. The inspector general's audit was received by the DHR licensing office March 4. DHR advanced the contract to ensure the continuity of care and safety for the youth placed at Lifeline. At the time there was no indication the safety of these youth was compromised. The extension provided Lifeline an opportunity to take corrective action to address the financial concerns raised in the audit.

3. *Were DHR and DHMH unaware of 911 calls alleged to have occurred in 2013?*

The state's primary concern is always the safety and well-being of the youth in our care. News reports have indicated that there were several significant events that may have occurred since May 2013. Not all of the events were reported by Lifeline to state agencies as required by law. Those that were reported did not involve abuse or neglect of youth in care. One consequence of lack of reporting may have been that it took longer for the agencies to identify serious health and safety problems at Lifeline.

4. *In early July, a medically fragile youth at Lifeline died. What is being done to understand the cause of his death?*

The death of every child is a tragedy, and we are committed to learning everything we can from this situation. We do not know at this time whether the death was related to the issues at Lifeline. Several reviews are automatically triggered whenever there is a fatality of a child in care. There is an autopsy underway by the Office of the Chief Medical Examiner to determine the cause of death. The autopsy is expected to be complete in late August or early September. Following the autopsy, OHCQ will finalize a mortality investigation that will be reviewed by the Mortality and Quality Review Committee.

Additionally, the local Department of Social Services is conducting a fatality review which includes an investigation of the circumstances surrounding the death. The investigation will include information from the local law enforcement, OCME, and OHCQ, as appropriate.

5. *Why didn't the agencies move faster to move the children at Lifeline?*

As the serious and sustained nature of problems became evident in May 2014, the agencies began planning for a transition. Staff were concerned about a safe and effective transition for the medically fragile children. This effort was complete by early July.

How can state oversight be improved?

DHR and DHMH have several initiatives underway to improve state oversight of group homes for medically fragile children and other regulated facilities. These include:

- Regulatory efficiency at DHMH: In January 2013, the OHCQ implemented a strategic planning process that includes the goal of regulatory efficiency -- how to best use its limited resources to protect the health and safety of vulnerable populations. The attachment provides additional information on the broad range of interventions that have resulted in providing more oversight of the quality of care throughout the healthcare system.

- Quality improvements at the Developmental Disabilities Administration: These include surveying individuals to receive feedback on services provided, increasing the role of the consumer-led DDA Waiver Advisory Committee, and developing a new structured approach to oversight across the three agencies.

- Rate reform at DHR. Since 2013, the Interagency Rates Committee (comprised of state agencies) has been working with the General Assembly, experts in the field, and stakeholders to reform the current rate system. The goal is to better meet the needs

of our children, to improve the alignment between the State's systems of care, and to allow for provider flexibility and innovation. This process is expected to be complete by the end of the fiscal year.

- Additional Staff: Both DHMH and DHR have increased the amount staff that are dedicated to licensing and contract oversight recently. At DHMH, the vacancy rate for inspectors is below 5%, lower than it has been for the last several years. OHCQ added two positions this year. DHR added three additional positions for contract monitoring and oversight in December 2013.

The challenges at Lifeline have led us to consider other opportunities to improve state oversight.

While our reviews are not yet complete, our recommendations to date center on the fact that Maryland law does not set out a clear approach for considering administrative and financial problems of organizations in evaluating licensure, contracting, and clinical care. With support from the Maryland General Assembly, the state could take additional action to prevent such problems, monitor such problems, and intervene when such problems develop.

Prevention

- Surety Bonds: One way to prevent administrative and financial problems is to require providers in Maryland to have surety bonds in order to provide services. Potential legislation could give DHMH flexibility to set surety levels for different types of providers, thus striking a balance between the size of the provider and the need to ensure that providers are fiscally solvent. These bonds would promote fiscal solvency among providers, block those providers with poor fiscal plans, and provide a mechanism for the State to recoup funding in the event of provider bankruptcy.

- Strengthened Reporting of Financial Stability: Moving forward, DHR will be requiring providers seeking state contracts to demonstrate financial stability. Additionally, DHR soon will be requiring providers to report financial issues to ensure they are in compliance with all licensing regulations. The draft policy has several triggers, including bankruptcy filings, tax and payroll issues, and failure to pay rent.

Monitoring and Oversight

- Increased Financial Reviews: The agencies are planning to expand use of Inspectors General to conduct administrative and financial reviews when red flags become available. Such oversight should be separated from clinical and programmatic oversight, as clinical inspectors are unlikely to be as effective as accountants, auditors -- let alone investigative journalists. At DHMH, we have asked our Inspector General to review whether the Department is receiving adequate information about fiscal and administrative concerns.

- Increased Enforcement Authority: Maryland agencies should be empowered to withdraw a license solely for administrative or financial problems, even if they have not yet affected clinical care. One step in the right direction will a proposed rule in the July 25 Maryland Register. This proposal will broaden the criteria for applying sanctions for non-compliance issues in Maryland group homes.

- Reporting: With respect to reporting, there is already a standard for police, fire, and medical officials to report suspected abuse or neglect to DSS. We are open to any reasonable way for state agencies to become aware of problems. We are reviewing options to better publicize opportunities to file complaints to families and consumers. DHMH also would like direct authority to fine providers for individuals with developmental disabilities for failing to make required reports, as it can with other provider types. Such a sanction can promote compliance before serious patient care issues emerge.

Conclusion

Our primary goal is to protect the safety of Marylanders in the care of the state or state-regulated facilities. Every challenge is an opportunity to improve, and we look forward to working with legislators to consider changes to Maryland law and regulation.